COVERED SERVICES

NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. For answers to specific questions regarding covered services, limitations, and exclusions, consult the *AHCCCS Medical Policy Manual* or contact the AHCCCS Office of Special Programs at (602) 417-4053.

The Arizona Long Term Care System (ALTCS) provides care for the developmentally disabled and the elderly and physically disabled. ALTCS provides institutional care and home and community based services to recipients who are at risk of institutionalization. Covered services include:

- ☑ Medical services
- ☑ Institutional services, including:
  - ✓ Nursing facilities
  - ✓ Inpatient psychiatric facilities for individuals under age 21 (RTCs)
  - ✓ Institutions for mental disease
  - ✓ Intermediate care facilities for mentally retarded (not covered for fee-for-service recipients)
- ☑ Home and community based services (HCBS) provided in lieu of institutionalization
- ☑ Hospice services
- ☑ Speech, physical, and occupational therapies when provided in nursing facilities and alternate residential facilities and as part of HCBS
- ☑ Behavioral health services
- ☑ Durable medical equipment and medical supplies
- ☑ Private duty nursing services

COVERAGE LIMITATIONS

- ☑ Private rooms in nursing facilities require physician orders and must be medically necessary.
- ☑ Services for ventilator dependent recipients must be provided in the individual's residence or a nursing facility.
- ☑ Respite care is limited to 30 days or 720 hours per contract year.
- ☑ Therapeutic leave days are limited to nine days per contract year.

COVERAGE LIMITATIONS (CONT.)

- ☑ Bed hold days for recipients admitted to a hospital for a short stay are limited to 12 days per contract year.
- ☑ Services provided in an institution for mental disease to recipients ages 21 – 65 are limited to 30 days per admission and 60 days per year.
- ☑ Habilitation services are a separate service category for individuals with developmental disabilities.

ELIGIBILITY

Application for ALTCS may be made at any of the ALTCS offices located throughout Arizona (See Exhibit 21-2). An individual may submit his or her own application or may have a family member or other representative make the application.

Applicants must meet financial and medical eligibility requirements. When it appears that an applicant is financially eligible for ALTCS, medical eligibility is determined by a Preadmission Screening (PAS). The PAS measures functional and medical disability to determine if the applicant is at risk of institutional placement.

Once determined eligible, recipients who are elderly or have physical disabilities are enrolled with a program contractor in their county of residence. Native Americans who maintain a residence on the reservation are enrolled with a tribal contractor and receive services on a fee-for-service basis. All persons with developmental disabilities are enrolled with the Department of Economic Security, Division of Developmental Disabilities (DES/DD).

CASE MANAGEMENT

All ALTCS recipients are assigned a case manager who is responsible for identifying, planning, obtaining, and monitoring appropriate and cost-effective medical and medically related services.

The AHCCCS Administration maintains intergovernmental agreements (IGA) with seven tribal governments for the delivery of ALTCS case management services to tribal members with ties to their respective reservations. The seven tribal governments are the Pascua Yaqui Tribe, Gila River Indian Community, Tohono O'odham Nation, San Carlos Apache Tribe, White Mountain Apache Tribe, Navajo Nation, and the Hopi Tribe.

CASE MANAGEMENT (CONT.)

Members of other tribes without an IGA are enrolled with the Native American Community Health Center (NACHC). NACHC and the tribal governments employ case managers who are responsible for coordinating ALTCS services to recipients. The tribes and NACHC receive a monthly capitation based on the number of tribal ALTCS members enrolled. All other services are provided and reimbursed on a fee for services basis.

Case manager authorization of ALTCS services is required unless:

- ☑ The recipient has Medicare or other insurance coverage *and* the services are covered by Medicare or the other insurance, or
- ☑ Services were provided during a period when the recipient was retroactively eligible.

Among the ALTCS services that require authorization are:

- ☑ Medically necessary non-emergency transportation
- ☑ Homemaker services, attendant care, and personal care
- ☑ Respite (in home and nursing facility)
- ☑ Home health nurse and home health aide
- ☑ Therapy (occupational, speech, respiratory, and physical)
- ☑ DME, all orthotic and prosthetic devices, and medical supplies
- ☑ Adult day health and home delivered meals
- ☑ Nursing facility services, including bed hold and therapeutic leave days

Acute care services such as in-patient hospitalizations for non-Medicare covered recipients and outpatient surgery must be authorized by the AHCCCS Prior Authorization Unit. Case managers generally are not involved with acute care service authorization.

To arrange services, the case manager first contacts the appropriate provider. Once arrangements are confirmed, the case manager enters the authorized services in the Case Management Service Plan in the AHCCCS system. An authorization letter is automatically sent to the provider (except nursing facilities) verifying the services authorized.

CASE MANAGEMENT (CONT.)

The information entered on the claim form must match what has been authorized and listed on the confirmation letter. The AHCCCS claims system matches the claim information against established authorizations and identifies the appropriate case manager authorization for the services that require authorization. If there are any discrepancies between the service billed and the authorized service, the system will not find the appropriate authorization, and the claim will be denied. (See Exhibit 21-1 for a sample authorization letter.)

NURSING FACILITY SERVICES

Nursing facilities provide care for the chronically ill and for those recuperating from illness who need nursing care but not hospitalization. Many facilities offer several levels of care and various specialized services such as therapies. A limited number serve patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems. (See Chapter 22, Nursing Facility Services, for a detailed description of nursing facility services)

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and community based services (HCBS) are services for ALTCS recipients residing in their homes who would otherwise require supervision and assistance through nursing facility services.

Covered HCBS services include:

- ☑ Assisted living facility
  - ✓ ALTCS covers services, except room and board, for EPD recipients who are physically or functionally unable to live independently in the community but can have their needs met safely while residing in an assisted living facility.
    - ☒ Assisted living homes provide room, board, personal care and supervision for up to 10 adults.
    - ☒ Adult foster care homes provide room, board, personal care, and supervision for one to four adults in a family environment
    - ☒ Assisted living centers (units only) provide room, board, personal care, and supervision for more than 10 adults.
    - ☒ Alzheimer's demonstration assisted living facilities provide room, board, and supervision to adults who require dementia care.

HOME AND COMMUNITY BASED SERVICES (CONT.)

Covered HCBS services include (Cont.):

☑ Adult day health

- ✓ Adult day health services provide supervision, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and other health-related services.

☑ Attendant care

- ✓ Attendant care services provide assistance with homemaking, personal care, general supervision, and companionship for a recipient in his/her own home as an alternative for those who may otherwise have to go to a nursing facility.

☑ Home delivered meals

- ✓ Home delivered meal services provide for one meal per day containing at least 1/3 of the Recommended Dietary Allowance to be delivered to a recipient's residence (Covered only for EPD recipients).

☑ Homemaker services

- ✓ Homemaker services provide assistance to a recipient in the performance of activities related to household maintenance

☑ Home health services

- ✓ Home health services provide intermittent in-home care for recipients such as nursing services, home health aides, medical supplies, equipment and appliances, and therapies (See Chapter 20, Home Health Care Services).

☑ Hospice services

- ✓ Hospice services provide supportive care for terminally ill recipients and their family or caregivers in the home or in an institution (See Chapter 23, Hospice Services).

☑ Personal care services

- ✓ Personal care services provide assistance to recipients who need help doing essential activities of daily living (i.e., eating, bathing, dressing)

☑ Respite services

- ✓ Respite services provide short term or intermittent care and supervision in order to provide an interval of rest or relief for family members
- ✓ Respite services include up to 30 days or 720 hours of service per calendar year
- ✓ Short-term in-home respite service cannot exceed 12 hours on a specific date

THERAPY SERVICES

Speech, physical, occupational, and respiratory therapies are covered when provided in alternative residential facilities and as part of HCBS. The services must be a medically prescribed treatment concerned with improving or restoring functions that have been impaired or permanently lost or reduced by illness or injury. Therapy services related to activities for the general good and welfare of recipients or activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the physician after any needed consultation with the qualified therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, all of the following conditions must be met:

- ☑ The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the client's condition;
- ☑ There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the client's restoration potential after any needed consultation with the qualified therapist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and
- ☑ The amount, frequency, and duration of the services must be reasonable.

BILLING FOR SERVICES

HCBS providers must bill for services on a CMS 1500 claim form. Claims for services will be compared with the case manager's authorization for the services. The match criteria includes:

- ☑ Provider ID
- ☑ Recipient ID
- ☑ Date(s) of Service
- ☑ Procedure Code
- ☑ Units of Service
- ☑ Diagnosis

If a nursing facility, HCBS, or therapy claim does not match the information on the Case Manager Service Plan, the claim will be denied.

BILLING FOR SERVICES (CONT.)

ALTCS recipients who receive long term care services may be responsible for paying a portion of the cost of their care. This payment liability is called share of cost (SOC).

The SOC calculation is a final step in the completion of the ALTCS application. SOC is calculated by subtracting certain expenses and deductions from the recipient's gross income. Calculations differ for recipients residing in nursing facilities and those receiving HCBS.

HCBS recipients have a personal needs allowance deducted from their income which usually is equal to the maximum income allowed for eligibility. Therefore, these recipients rarely have a SOC. Occasionally, an HCBS recipient will have income that is not counted toward eligibility in addition to other types of income or may receive a reduced personal needs allowance. In this case, the recipient may have a SOC.

Recipients in a nursing facility have a personal needs deduction of 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

Deductions for spousal, family, or home maintenance; medical insurance premiums; and non-covered medical expenses may reduce the amount of a recipient's SOC. Because a recipient's income and expenses may fluctuate from month to month, SOC is calculated monthly.